

TUNBRIDGE WELLS BOROUGH COUNCIL

Mind The Gap

Health Inequalities Action Plan 2015-2019

Sarah Richards

6/1/2015

For further information please contact: Sarah Richards, Healthy Lifestyles Co-ordinator,
Room 8, Town Hall, Royal Tunbridge Wells, Kent, TN1 1RS, t. 01892 554411, e.
health@tunbridgewells.gov.uk

Contents

| | |
|---|----|
| 1. Introduction..... | 3 |
| What are health inequalities? | 3 |
| Why do we need this plan?..... | 4 |
| 2. Who will do what? | 4 |
| Strategic Partners..... | 5 |
| KCC | 5 |
| TWBC..... | 5 |
| Kent Health and Wellbeing Board (HWB) | 5 |
| West Kent Health and Wellbeing Board (HWB) | 5 |
| West Kent CCG | 5 |
| Other key partners | 5 |
| 3. Health Profile Summary | 6 |
| 4. Our Priorities in Tunbridge Wells | 7 |
| Aspirational Targets:..... | 7 |
| 1. Self Harm..... | 7 |
| 2. Excess Winter Deaths | 7 |
| 3. Falls Prevention | 7 |
| 4. Adult and Child Obesity | 7 |
| 5. Smoking Related Deaths | 7 |
| 6. Alcohol Misuse..... | 7 |
| 5. Rationale for top 6 priorities in Tunbridge Wells..... | 9 |
| Self Harm..... | 9 |
| Excess Winter Deaths | 11 |
| Falls Prevention | 12 |
| Child and Adult Obesity | 13 |
| Smoking Related Deaths | 15 |
| Alcohol Misuse..... | 16 |
| 6. Actions for 2015/16 | 18 |
| 7. Appendix A | 28 |
| List of Strategic Partners including HAT members | 28 |
| 8. Appendix B | 29 |
| Glossary..... | 29 |

1. Introduction

The Health Inequalities Action Plan has been developed by Tunbridge Wells Borough Council in partnership with members of the Tunbridge Wells Health Action Team (HAT). The HAT meets quarterly and includes a range of health and social care partners whose work contributes to improving the wider determinants of health. Its members include associates from across the local authority; such as the planning and housing departments; KCC public health; as well as members of the voluntary and community sector, such as Good Neighbors, West Kent Mind and Imago. It is a subgroup of the West Kent Health and Wellbeing Board; enabling two-way communication, partnership working and increased understanding of services at a local level.

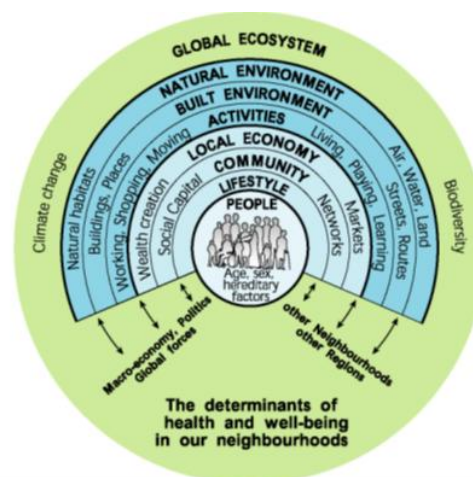
This plan sets out our collective core priorities and actions being taken to improve health outcomes across the borough, and specifically in the areas of need. Members of the HAT will be responsible for monitoring and reporting on progress during the 5 year life-span of the plan. The performance monitoring collected by the HAT will be then be used for making recommendations on future commissioning plans.

In preparation for this action plan, a more detailed Health Inequalities Needs and Actions Analysis was undertaken. This was informed by the Kent Joint Strategic Needs Assessment ([JSNA] 2012), Tunbridge Wells Health Profile (APHO, 2014¹) and the Health and Social Care Maps for Tunbridge Wells Borough².

Figure 1: Barton & Grant (2006)

What are health inequalities?

Health inequalities are differences in health status and health outcomes within and between communities and are the result of a complex interaction of various factors, including but not limited to: housing conditions, planning, access to and quality of leisure services, air quality and lifestyle choices such as diet and smoking status. These interactions are described in figure 1.



¹ APHO (2014) <http://www.apho.org.uk/resource/item.aspx?RID=50493>

² KMPHO (2014) <http://www.kmpho.nhs.uk/health-and-social-care-maps/>

Why do we need this plan?

Marmot (2010)³ recognised the role that the local authorities have to play in improving the wider determinants of health. This led to the transfer of responsibility for preventative health care and public health budgets from the NHS into top tier local authorities on 1 April 2013. Under the operational control of Kent County Council (KCC) Public Health, Tunbridge Wells Borough Council now has a delegated responsibility for some health improvement services in Tunbridge Wells.

Our health needs are very different to Kent as a whole; whilst Tunbridge Wells' residents generally experience better health outcomes, health inequalities do exist within our borough. Therefore a targeted, localised, partnership approach is required to maximise outcomes and make the best use of all available resources. This action plan outlines our collective commitment and actions for improving the health of people in Tunbridge Wells. Our approach will be targeted and proportionate, helping to close the gap between the least and most deprived. Marmot's life course approach will be used as a foundation for this plan. Marmot's approach is based on 6 policy areas,

- I. Give every child the best start in life
- II. Enable all children, young people and adults to maximise their capabilities and have control over their lives
- III. Create fair employment and good work for all
- IV. Ensure a healthy standard of living for all
- V. Create and develop healthy and sustainable communities
- VI. Strengthen the role and impact of ill-health prevention

Kent covers a large area and therefore this document enables us to drill down into the data much further than any Kent-wide strategy has the capacity to do and as such can provide support to project proposals and funding applications, such as the £45,000 which was recently secured for installation of an outdoor gym to improve rates of physical inactivity in Sherwood.

The annual cost of health inequalities equates to £36-40 billion pounds nationally through lost taxes, welfare payments and NHS treatments. Health inequalities are largely preventable and tackling them is much more affordable than the cost of treating the outcomes of poor lifestyle choices and living conditions.

2. Who will do what?

Our action plan provides a framework and tools to identify, analyse and evaluate actions that can contribute to reducing health inequalities in Tunbridge Wells. The HAT will own the plan, but will not be the sole owner of some of the actions contained within it. The plan seeks to combine priorities and actions from across the authority and partners that seek to reduce health inequalities in Tunbridge Wells.

Work on reducing health inequalities cannot be tackled by one stand-alone organisation and needs the support of a wide range of local partners to make an impact. Tunbridge Wells Borough Council held a Health Inequalities stakeholder workshop on 9th December 2014

³ Marmot (2010) Fair Society, Healthy Lives

where a range of partners were asked to identify how their work could contribute to reducing health inequalities in Tunbridge Wells. The outcomes of the workshop are the actions that are included within this plan.

Strategic Partners

KCC

Has the primary responsibility for public health and tackling health inequalities across the county through services such education and social care. KCC has written the overarching Mind The Gap plan⁴, to which this plan adds.

TWBC

In our role as place shapers, the Borough Council has led on the production of this document, bringing together partners from the local authority, primary care, voluntary and community sector to monitor progress against our priorities through the HAT meetings. The borough council will be responsible for refreshing the plan. In addition the Borough Council's health team deliver a number of health improvement activities commissioned by KCC.

Kent Health and Wellbeing Board (HWB)

Includes leaders from the health and social care system working together to improve the health and wellbeing of their local populations. The HWB is responsible for producing the JSNA⁵ and Joint Health and Wellbeing Strategy (JHWBS⁶), which assesses current and future health needs alongside the assets, whilst encouraging integrated health and social care services.

West Kent Health and Wellbeing Board (HWB)

The local HWBs focus on improving the lives of people living in their Clinical Commissioning Group (CCG) area through joined up commissioning across the NHS⁷, social care, district councils, public health and other services.

The Chief Executive and Cabinet Member for health and communities both attend each of these HWBs.

West Kent CCG

As the new commissioners for health services locally, West Kent CCG is a key partner in reducing health inequalities in the borough.

Other key partners

It would not have been possible to produce the action plan without contributions from members of the HAT and our strategic partners who are acknowledged in appendix A. This has enabled us to improve partnership working and build a greater awareness of what is being delivered and where.

⁴ KCC(2012) http://www.kent.gov.uk/_data/assets/pdf_file/0008/14777/Mind-the-Gap-Building-bridges-to-better-health-for-all.pdf

⁵ KMPHO (2013) <http://www.kmpho.nhs.uk/jsna/>

⁶ http://www.kent.gov.uk/_data/assets/pdf_file/0014/12407/Joint-Health-and-Wellbeing-Strategy.pdf

⁷ <http://www.westkentccg.nhs.uk/about-us/our-plans-reports-and-strategies/>

Partners who are delivering on actions that contribute to our 6 priorities are highlighted alongside the actions/ interventions in section 6.

3. Health Profile Summary

The Association of Public Health Observatories (APHO, 2014) produces an annual summary of the health of the population for each Local Authority. In 2014, our profile⁸ found that the health of people in Tunbridge Wells is generally better than the England average.

Tunbridge Wells boasts many opportunities to exercise in leisure time as well as relax in our attractive parks and open spaces, all of which have a proven link with heightened physical and mental wellbeing⁹. Residents are expected to live on average 3.2 years longer than the England average and 1.4 years longer than our Kent and Medway neighbours. However a 6.03 year gap in life expectancy does exist within our borough¹⁰. Deprivation is lower than the England average, however about 11.6% (2,500) of children do live in poverty (Appendix B). The Health and social care maps produced by the Kent and Medway Public Health Observatory (KMPHO, 2015) allow us to identify our local priorities including where these children reside, allowing us to target our resources.

Levels of teenage pregnancy (13.5%), GCSE attainment (74.4%) and unemployment (0.7%¹¹) are better than the England average. There is a shortage of affordable housing in Tunbridge Wells, particularly in the rural areas. Access to goods and services in rural areas also presents a barrier. This indicates a need for community based services.

Estimated levels of adult physical activity are better than the England average; however pockets of high inactivity levels do exist within our borough. Rates of sexually transmitted infections and TB are better than average. Rates of statutory homelessness, violent crime, long term unemployment, drug misuse, early deaths from cardiovascular diseases and early deaths from cancer are also better than average. Information and data relating to health behaviours and external influences on health can be seen throughout the objectives section.

⁸ APHO (2014) Tunbridge Wells Health Profile

⁹ [http://www.kentnature.org.uk/assets/files/Health/Using-the-natural-environment-to-deliver-better-health-in-Kent---final-\(KCC-version\)---FINAL.pdf](http://www.kentnature.org.uk/assets/files/Health/Using-the-natural-environment-to-deliver-better-health-in-Kent---final-(KCC-version)---FINAL.pdf)

¹⁰ KMPHO (2015) Health and Social Care Map; Inequalities – Tunbridge Wells
<http://www.kmpho.nhs.uk/health-and-social-care-maps/tunbridge-wells/> [accessed online 8.6.15]

¹¹ Business Intelligence Statistical Bulletin February 2015 www.kent.gov.uk/research

4. Our Priorities in Tunbridge Wells

Aspirational Targets:

Through the HAT we will work together to offer and monitor the initiatives and interventions, which are directly attributable to our priorities; these are described in section 6. We will offer evidence based recommendations to the commissioners based on health intelligence and our collective knowledge of our borough's communities. Our aim is to ensure the right services are provided in areas where they are needed most. In doing so, we have set the following aspirational targets:

1. **Self Harm** – by 2016 we will identify the best way to measure the impact of initiatives to reduce self harm and by 2017 ensure this is reflected in local commissioning
2. **Excess Winter Deaths** - we will achieve an overall reduction by 2019
3. **Falls Prevention** – we will work with KCC and West Kent CCG on their plans for the implementation of an integrated framework for falls prevention and seek to reduce our falls rate to below that of Kent.
4. **Adult and Child Obesity** – we will aim to achieve a reduction in the percentage of children who are overweight or obese at year 6 and reception using 2014 as the baseline
5. **Smoking Related Deaths** – we will aim to facilitate a reduction in the number of deaths attributable to smoking
6. **Alcohol Misuse** – we will seek a reduction in the number of annual alcohol related stays in hospital by 2019

These priorities will be underpinned by an overarching commitment to improving physical and intellectual access to health and social care services in rural communities; including securing rural representation on the HAT board.

Table 1: Baseline figures that we will measure our progress against:

| Priority | Marmot (2010) main policy objectives | 2014 Baseline |
|----------------------------|---|---|
| 1. Self Harm | Reduce risk taking behaviours in young people | 217.6 per 100,000 (2014 Health Profile) |
| 2. Excess Winter Deaths | Reduce fuel poverty by supporting development of warm homes | Excess winter deaths (three year) Local number 77 Local value 27.6 (2014 health profile) |
| 3. Falls Prevention | Support older people to live safe, independent and fulfilled lives | 845 Hospital admissions for falls per 100,000 population during 2013/14 (Older People Health & Social care maps ¹²) Hip fractures in people aged 65+ is 117 per year (2014 health profile) |
| 4. Child and Adult Obesity | Promote healthy weight for children Reduce the gap in health inequalities across the social gradient | Reception Year (age 5) Overweight: 14.3% Reception Year Obese:7.8% Year 6 (age 11) Overweight: 14% Year 6 Obese:15.6% (HSCIC, 2014 ¹³) |
| 5. Smoking Related Deaths | Strengthen the role and impact of ill-health prevention | 19.3% (2014 health profile) |
| 6. Alcohol Misuse | Support safe communities | Hospital stays for alcohol related harm Local number 515 Local value 470 (2014 health profile) |

¹² <http://www.kmpho.nhs.uk/health-and-social-care-maps/tunbridge-wells/>

¹³ Health and social care information centre (2014) <http://www.hscic.gov.uk/catalogue/PUB16070>
[accessed online March 2014]

5. Rationale for top 6 priorities in Tunbridge Wells

On many measures of health inequality, we fair significantly better than the Kent and England average, which makes priority setting a challenge. We have explored the data at ward and Lower Super Output Area level (LSOA), allowing us to be more detailed in our approach and identify the areas and ways in which to tailor our support.

Self Harm

Mental illnesses are very common among people under 65; nearly half of ill health is mental illness. Mental illness is generally more debilitating than most chronic physical conditions and yet only 25% of all those with mental illnesses such as depression are in treatment. With a combined economic and social cost of £105bn/ year, preventative measures require significant investment. People with poor physical health are at higher risk of experiencing mental health problems and people with low mental wellbeing are at greater risk of developing physical ailments. Kent's ambition is for services to be more integrated.

We were able to identify a number of holistic mental health services available for adults in Tunbridge Wells as part of the mapping that was done for the Health Inequalities Needs and Actions Analysis. This supports the actions outlined in the Government's plans for mental health reforms.¹⁴ Services that support a reduction in self harm are specifically focused on here as the rate of hospital stays for self harm (217.6 per 100,000 population) is significantly higher than the Kent and England average.

Making self harm a priority, which is supported by a range of delivery actions as outlined in section 6 is one example of how this Action Plan links to the Kent Joint Health and Wellbeing Strategy which outlines '*People with mental health issues are supported to 'live well'*'¹⁵ as one of it's strategic outcomes. Since self harm and suicide are linked it specifically supports the '*preventing suicides*' action as described in the Government's policy on mental health reform.

Distribution of figures for self-harm follow the pattern of distribution of Mental Illness in Tunbridge Wells; with some wards presenting a significantly higher rate of self harm in comparison to Tunbridge Wells generally.

¹⁴ <https://www.gov.uk/government/publications/2010-to-2015-government-policy-mental-health-service-reform/2010-to-2015-government-policy-mental-health-service-reform>

¹⁵ <http://www.kent.gov.uk/social-care-and-health/health/health-and-public-health-policies/joint-health-and-wellbeing-strategy>

Figure 2: Showing the distribution of mental illness in Tunbridge Wells

Mental Illness Needs Index

- in different types of area, people are more or less likely to suffer from mental illnesses. To some extent this can be predicted from characteristics of the population measured by the census or other types of survey. Mental health needs indices estimate by how much. A needs index of 0.8 suggests that there will be 20% less illness in an area than in the country as a whole, an index of 1.2 suggests 20% more.

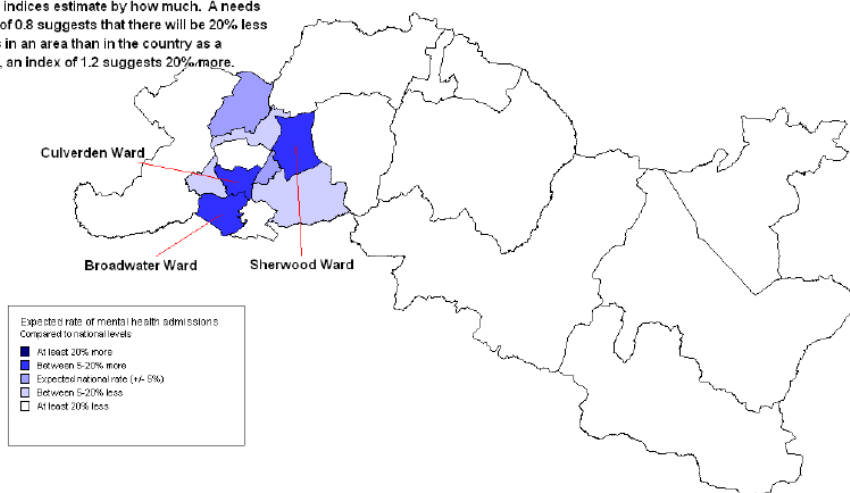


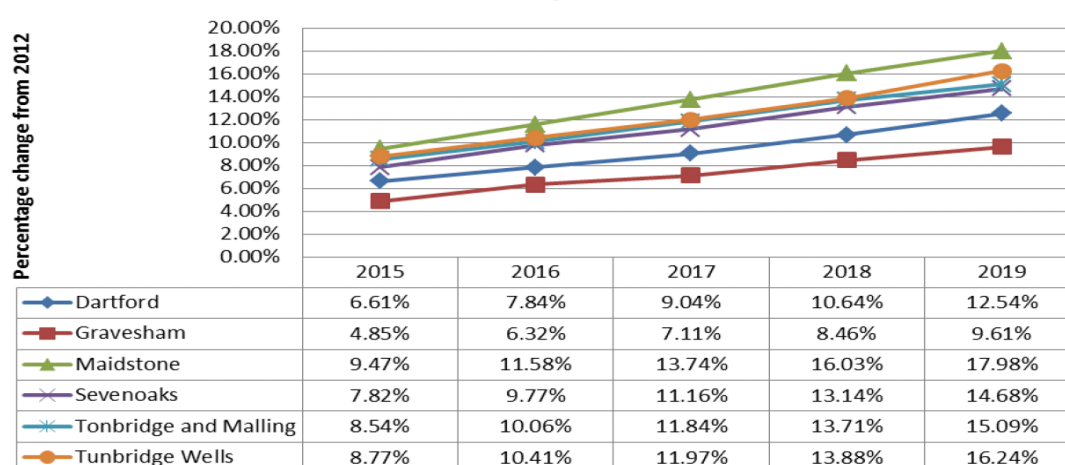
Table 2: Showing hospital admissions by ward for deliberate Self-Harm cases in Tunbridge Wells 2013/14

| Ward Code | Ward Name | Total |
|--|------------------------------|------------|
| E05005130 | Benenden and Cranbrook | 13 |
| E05005131 | Brenchley and Horsmonden | * |
| E05005132 | Broadwater | 27 |
| E05005133 | Capel | * |
| E05005134 | Culverden | 25 |
| E05005135 | Frittenden and Sissinghurst | * |
| E05005136 | Goudhurst and Lamberhurst | 14 |
| E05005137 | Hawkhurst and Sandhurst | 18 |
| E05005138 | Paddock Wood East | 6 |
| E05005139 | Paddock Wood West | 8 |
| E05005140 | Pantiles and St Mark's | 11 |
| E05005141 | Park | 13 |
| E05005142 | Pembury | 16 |
| E05005143 | Rusthall | 23 |
| E05005144 | St James' | 21 |
| E05005145 | St John's | 14 |
| E05005146 | Sherwood | 28 |
| E05005147 | Southborough and High Brooms | 37 |
| E05005148 | Southborough North | 9 |
| E05005149 | Speldhurst and Bidborough | 9 |
| Tunbridge Wells District Total | | 299 |
| *The data has been suppressed as the numbers are too low | | |

Excess Winter Deaths

Tunbridge Wells is expected to see a steep increase in the proportion of the population aged over 65 in the next four years. This is significant factor because people of retirement age can become socially isolated and become less active and able to keep themselves warm through movement. This substantially increases the heating needs of older people that they are not necessarily able to meet due to fuel poverty (appendix B). This has implications for the health and social care and council services, due to the need for assistance such as the Warm Home Discount Scheme¹⁶ and the Kent Warm Homes Scheme,¹⁷ to help reduce the negative impacts of cold homes.

Figure 3: Graph show projected population change in those aged 65 and over in Kent



In addition to fuel poverty, excess winter deaths can be attributed to slips, trips and falls, which link priorities 2 and 3. Fuel poverty occurs when people in a household need to spend more than 10 percent of their total income in order to heat their home. In Tunbridge Wells, 8.6% of households are estimated to be living in fuel poverty. This is approximately 4157 households. This proportion is equal to the Kent average but higher than the South East average (8.1%¹⁸). The local value (3 year average) for excess winter deaths is 27.6 is significantly higher than the England 3 year average which is 16.5 (APHO, 2014).¹⁹

The people most likely to die or become ill during the cold weather are those least able to afford to heat their homes. Living in a cold home can lead to or worsen a large number of health problems including heart disease, stroke, respiratory illness, falls, asthma and mental health problems.

¹⁶ <https://www.gov.uk/the-warm-home-discount-scheme/what-youll-get>

¹⁷ <http://www.kent.gov.uk/about-the-council/campaigns-and-events/warm-homes>

¹⁸ <https://www.gov.uk/government/statistics/2013-sub-regional-fuel-poverty-data-low-income-high-costs-indicator>

¹⁹ APHO(2014) <http://www.apho.org.uk/resource/item.aspx?RID=142390>

Tunbridge Wells has a high number of owner occupied properties. In addition there are many people living in large, valuable properties, which are expensive and inefficient to heat; resulting people who are 'cash poor, property rich'. Our borough also has a number of rurally isolated properties which may still be relying on oil for fuel.

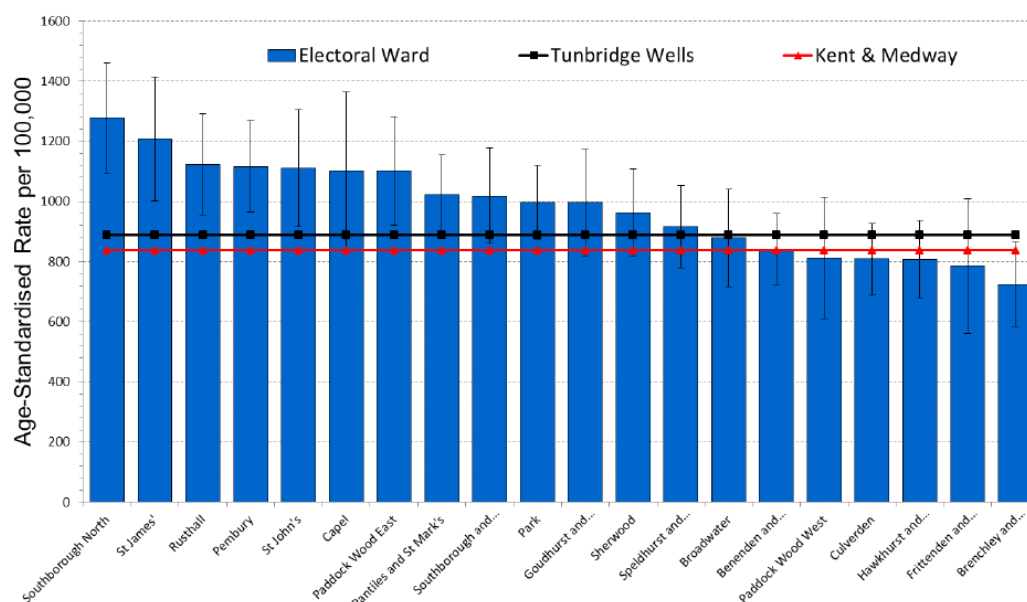
With this as our priority we will work together, adopting a 'making every contact count approach' to ensure that the most vulnerable people are aware of and supported to access the schemes and services that are available to them. This will help to reduce the negative impacts of cold homes.

Falls Prevention

Older people are more vulnerable to falls than others as long term health conditions increase the chances of a fall. Most falls do not result in serious injury but there is a risk of problems such as broken bones. A fall can lead to injury and sometimes death. Falls can also have an adverse psychological impact on elderly people, such as reduced confidence, becoming withdrawn and a loss of independence.

Around one in three adults over 65 who live at home will have at least one fall per year and about half of these will have more frequent falls. Falls in Tunbridge Wells are above the Kent and Medway average and linked to excess winter deaths and therefore a priority.

Figure 4: Graph showing the distribution of falls in the borough compared to the Kent and Medway average



Child and Adult Obesity

Obesity is a leading cause of preventable morbidity and mortality nationally. Modelled estimates show that adult obesity levels (15.2%, [APHO, 2014]) in Tunbridge Wells are lower than the England average and have fallen by 7.7% in the past 5 years.

Being overweight is having more body fat than is optimally healthy and is defined by having a Body Mass Index (BMI) which is between 25 -29.9. BMI equals a person's weight in kilograms divided by the square of the person's height in metres. Obesity is defined by excessive fat accumulation that has a significant impact on health. Obesity is measured by a BMI which is above 30. Since children and adolescents BMI varies with age and sex, growth charts must also be used. In England, the British growth reference charts are used to determine weight status according to the child's age and sex for the National Child Measurement Programme (NCMP). All children in year R (age 4-5) and year 6 (age 10-11) are opted into the NCMP and will have their weight and height measured by school nurses unless they opt out. Letters are then sent to parents informing them of the results and where they can access support. The borough council delivers weight management activities commissioned by KCC.

Obesity is linked to a number of debilitating and life threatening conditions including diabetes, coronary heart disease, certain cancers, stroke, high blood pressure and osteoarthritis.

Tunbridge Wells has lower rates of obesity among 5 year olds (7.8%) than most other areas in Kent. However, the rate (14.3%) of overweight children at reception year is comparable to or slightly higher than, most other areas in Kent. Fourteen per cent of 11 year olds are overweight. Figures 5 and 6 show that, year R and year 6 obesity levels are above the borough average in certain wards. Data from the National Child Measurement Programme (NCMP) also shows that in Tunbridge Wells, 7.8% of five year olds are obese, by the time they reach age 11, obesity levels have doubled to 15.6%²⁰.

Overweight children are at an increased risk of becoming obese. Similarly, childhood obesity is associated with a higher chance of obesity, premature death and disability in adulthood and so this is a priority.²¹ Mounting evidence suggests that a critical period during which to prevent childhood obesity and its related consequences is before the age of five. The best thing we can do for children from 0-5 is create ways of life which continue to make obesity unlikely, which is why breastfeeding support services and health visiting are fundamental actions outlined in our action plan.

This data from the NCMP has allowed us to identify schools within the wards with the highest levels of childhood obesity and the biggest increase in prevalence from year R to year 6. With this data we can focus our work more effectively. Growing up in a rural area does not offer protection against obesity and as such it is important we focus on these areas as much as those within our towns when the data shows a need.

²⁰ Health and social care information centre (2014) <http://www.hscic.gov.uk/catalogue/PUB16070>
[accessed online March 2014]

²¹ WHO(2015) <http://www.who.int/mediacentre/factsheets/fs311/en/>

Figure 5: Obesity in Year R Tunbridge Wells 2010/11 - 2012/13

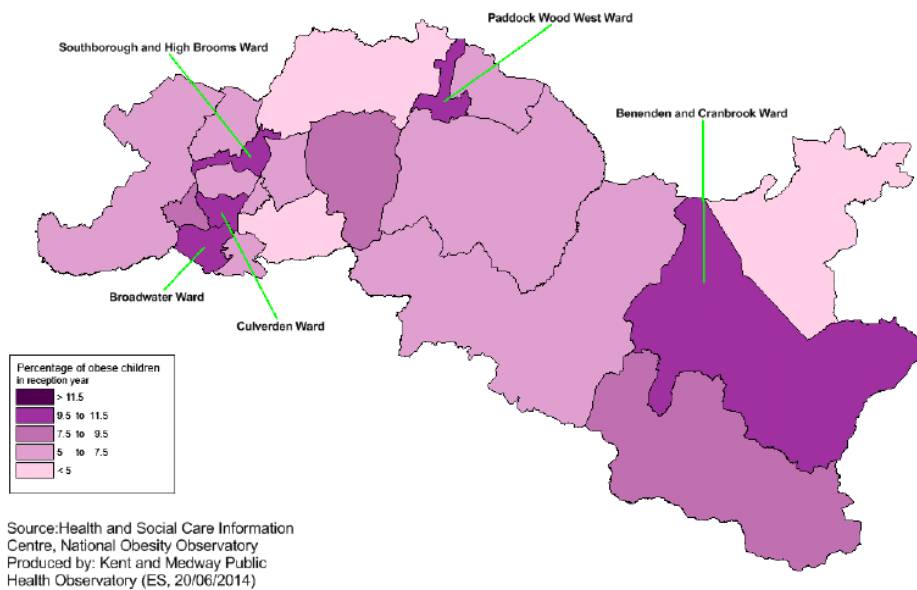
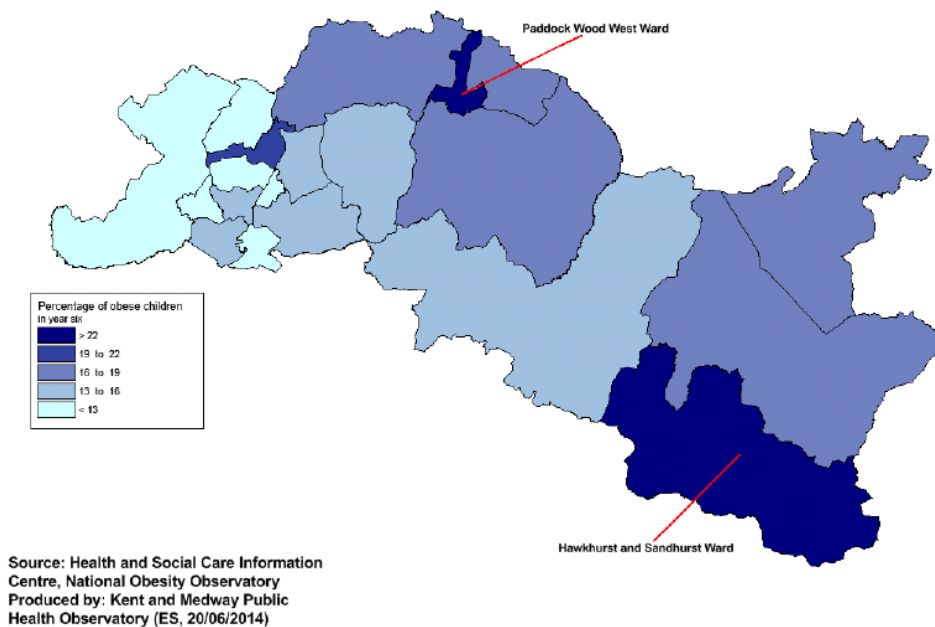


Figure 6: Obesity in Year 6 Tunbridge Wells 2010/11 - 2012/13, KMPHO



Smoking Related Deaths

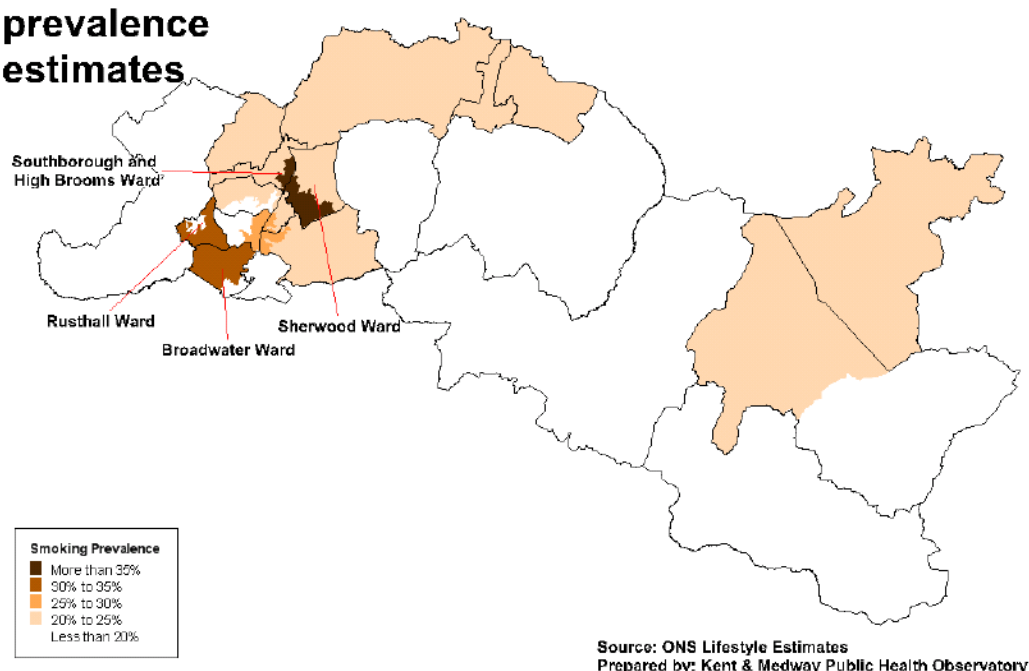
Smoking is the biggest single contributor to the shorter life expectancy experienced in Tunbridge Wells and contributes substantially to the cancer burden. Smoking has been identified as the single biggest cause of inequality in death rates between rich and poor in the UK. Death rates from tobacco are two to three times higher among disadvantaged social groups than among the better off (ASH, 2012²²). As smoking is responsible for half the difference in deaths across socio-economic groups, tobacco control also has a major role to play in reducing health and social inequalities (ASH 2008, Beyond Smoking Kills²³). Smoking rates are highest among manual workers, in the lower socio-economic groups and certain minority and vulnerable groups.

Estimates suggest that smoking costs the NHS £1.5 billion per year (National Institute for Health and Clinical Guidance²⁴ [NICE]) and is the main cause of preventable morbidity and premature death in England.

Whilst smoking related deaths (227/ 100,000 population, which represents 145/ year) are not significantly different to the England average, the rate (19.3%) has increased since 2010 (17.5%). Efforts are needed to support the many young people who experiment with tobacco and go on to become smokers, as well as those with mental health conditions and those in routine and manual employment.

Figure 7: Showing smoking prevalence by ward in Tunbridge Wells

prevalence estimates



²² ASH(2012) <http://www.kmpho.nhs.uk/jsna/smoking/>

²³ ASH(2008) http://www.ash.org.uk/files/documents/ASH_691.pdf

²⁴ NICE <http://www.kmpho.nhs.uk/jsna/smoking/>

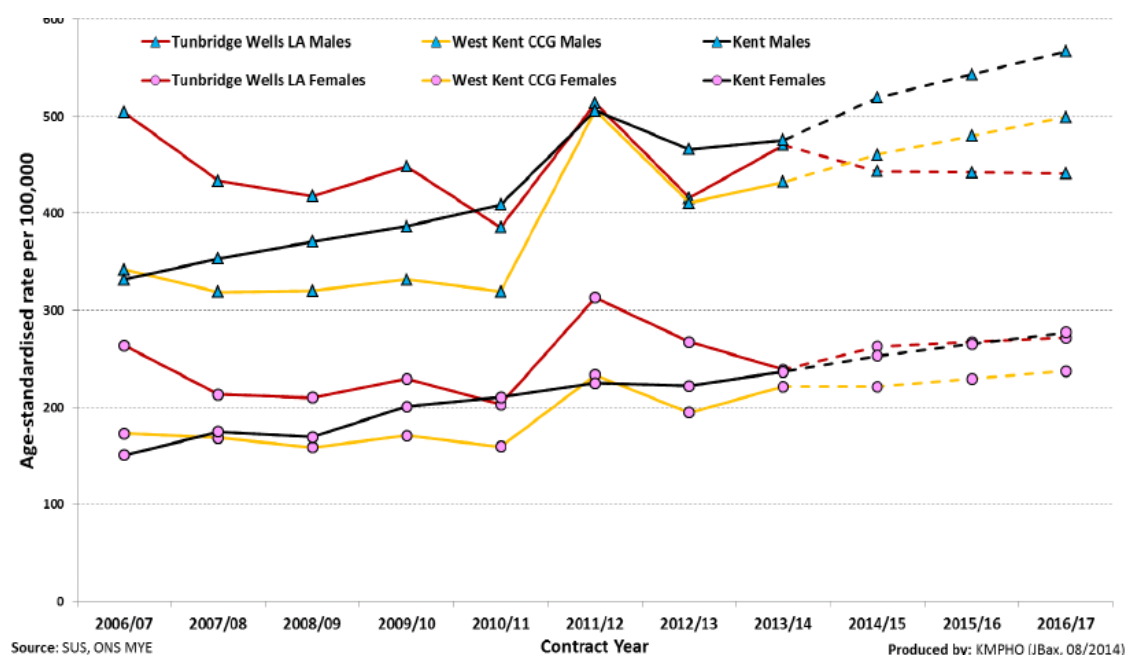
Alcohol Misuse

The impact of alcohol misuse is widespread; it encompasses alcohol related illness and injuries, mental health problems as well as significant social impacts including crime and violence, teenage pregnancy, loss of workplace productivity and homelessness. National data indicates that alcohol-related death rates are about 45% higher in areas of high deprivation.

The rate of alcohol specific hospital stays among those under 18 was 37.4 in Tunbridge Wells, which is not significantly different to the England average. The rate of alcohol related harm hospital stays was 470, per 100,000 population, better than the average for England but consistently higher than the Kent average. Whilst alcohol related harm in the borough is better than the England average, modelling predicts an increase in higher risk and binge drinking, particularly for those aged over 45.

The Public Services Board, comprised of strategic partners (including Tunbridge Wells Borough Council, KCC, the West Kent CCG, TCHG and Kent Police), have identified a need to make socialising in Tunbridge Wells safer for residents and visitors²⁵. Substantial savings, in terms of health provision and policing, could be made by adopting various methods of controlling the night time economy, through enforcement, education and health initiatives. This is a priority for 2015/16.

Figure 8: Showing hospital admissions for alcohol related harm within the West Kent CCG area



25

Figure 9: Showing quarterly breakdown of hospital admissions for mental and behavioural disorders due to psychoactive substances including alcohol in Tunbridge Wells compared with Kent

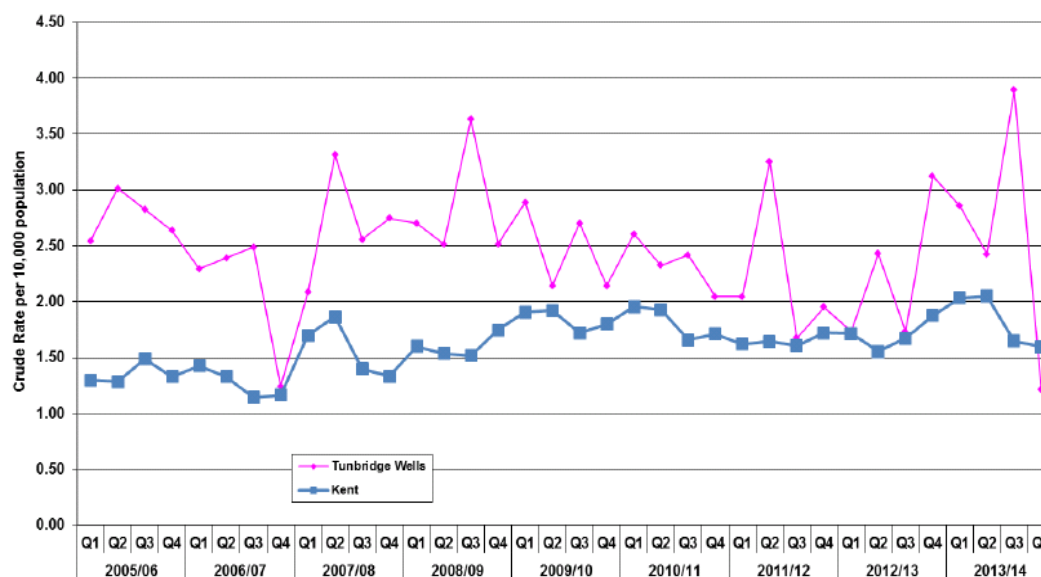
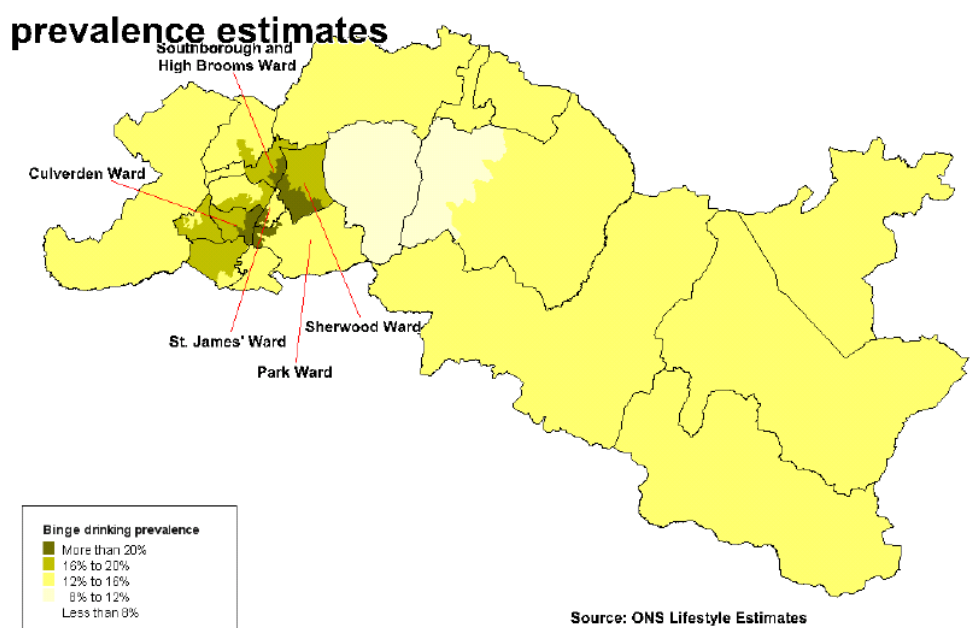


Figure 10: Showing modelled estimates of alcohol consumption by ward in Tunbridge Wells



6. Actions for 2015/16

| Priority 1: Self Harm | | |
|--|---------------------------------|--|
| Marmot (2010) Policy Area: Enable all children, young people and adults to maximise their capabilities and have control over their lives Strengthening the role and impact of ill health prevention | | |
| Action/ Intervention | Primary Agency/ agencies | Measure |
| Policy area 1b.1: Support parents so that they can raise emotionally and mentally healthy children | | |
| To support families in turning their lives around through targeted and intensive support of Families First | KCC/ TWBC | Support with key health and social issues affecting them |
| Policy area 1b.2: Encourage access to health services for all | | |
| To provide timely and appropriate advice and support with issues and concerns that are affecting individuals through the Health Help Now App in West Kent | West Kent CCG | No. of site visits |
| Policy area 2.2: Reduce risk taking behaviours in young people | | |
| To provide support for the issue of mental health (including self harm) in 4 schools (minimum), in areas of high need using a range of intervention methods including whole school approach, staff training, one-to-one and group work; supporting a reduction in emergency admissions for self harm in under 18s. | SALUS/ TWBC | No. of Schools and individuals worked with. Improved emotional wellbeing, attendance, attainment and behaviour change among young people receiving a direct intervention. Referrals to partners such as Troubled Families and Child Adolescent Mental Health Services. |
| To increase awareness of youth suicide and mental health problems, through SAFE spaces, assemblies, PSHE lessons, training and signposting that will support a reduction in emergency admissions for self harm in adults and under 18s. | Imago (SAFE project) | Increased awareness of youth suicide amongst YP Increased awareness of the danger signs of mental health difficulties among YP Increased awareness of the needs of YP with mental health issues among external professionals Captured by pre and post intervention analysis |
| To offer safe support and advice to vulnerable people late at night. | Street pastors | Reduce the burden on other services such as police and ambulance. |

| Policy area 6.3 Mental Health | | |
|--|-------------------------------------|---|
| To provide weekly art therapy to those with mental health issues, learning disabilities, emotional and behavioural problems through 'Mindwell' | TCHG | Improved social skills and co-ordination for participants |
| To provide help to people with mental health conditions through books on prescription, as well as the mental health benefits of reading for pleasure | KCC libraries and archives services | No. of referrals |
| Policy area 6.5: Make every contact count | | |
| To deliver Mental Health First Aid training available free to all front line staff | KCC and Mind West Kent | No. of sessions held No. of attendances and variety of organisations represented Training evaluations |

| Vulnerable Adults & Older Persons | | |
|--|------------------------------------|--|
| Priority 2: Excess Winter Deaths | | |
| Priority 3: Falls Prevention | | |
| Marmot (2010) Policy Areas: Creating and developing healthy sustainable places and communities Enabling all children, young people and adults to maximise their capabilities and have control over their lives | | |
| Action/ Intervention | Primary Agency/ agencies | Measure |
| Policy area 2.3: Support older people to live safe, independent and fulfilled lives and support disabled people to live independently at home | | |
| To provide disabled facilities grants to clients who require adaptations and equipment enabling them to maintain their independence, quality of life and live safely in their homes. | TWBC private sector housing team | No. of grants issued |
| To risk assess properties in line with the Housing Health and Safety Rating System (for hazards such as falls on stairs or in the bath), following a vulnerable person enquiry/ complaint, which leads to action (such as provision of handrails, bathing equipment or handyperson service). | TWBC private sector housing team | 500 handyperson jobs per annum People signposted to suitable support services |
| To co-ordinate referrals from clients to social services, VCS and carers who will assist client to get repairs/ heating or insulation improvements done, for a more integrated approach | TWBC private sector housing team | Quicker, more effective processing of improvements helping people stay in their home for longer |
| To deliver the care navigator scheme which supports people over 50 to access services including disabled adaptations, referrals, grants and benefits assessments. | Imago | No. of people supported, signposted and referred. |
| To advocate for and provide support to people aged 65+ enabling them to take control over their care needs and decisions that affect them through more informed choices. | Good Neighbour Project | People are supported to stay in their own homes for longer |
| To improve postural stability and reduce the risk of falling (and related injuries) for people aged 65+ who are at risk or those with a long standing medical illness through strong and steady classes. | Good Neighbour Project | Risk of falling and injuries is reduced and people are able to stay in their own home for longer. No. of people supported |
| To develop services to assist people living with dementia and their carers through the 'Reading Well' books on prescription for dementia scheme | KCC libraries and archives service | People more confident in understanding and living well with dementia |

| | | |
|--|---|--|
| and 'Home Library' delivery service. | | |
| To raise public and professional awareness of the experience and needs of people affected with dementia (and their carer networks) through training, dementia friends sessions, public events (dementia awareness week), cafes, outreach, carer support and information. | Alzheimer's society, Kent & Medway Age UK, Carers First, Crossroads, Good Neighbours, TWBC and TCHG | Which contributes towards the West Kent CCG's target to Improve dementia diagnosis rates from 51% to 67% |
| Policy area 5.4: Reduce fuel poverty by supporting development of warm homes | | |
| To increase up take of Eco funding measures to provide warm insulated homes | TWBC housing renewal team | No. of homes assisted |
| To increase take up of warm homes bonus for vulnerable people (aged 65+ with a long term health condition). | TWBC housing renewal team | No. of homes identified and assisted. |
| To encourage, educate and enforce measures in rented properties to improve thermal efficiency | TWBC housing renewal team | From 01/04/2018, it will be illegal to let properties when EPC lower than E. |

| Priority 4: Child and Adult Obesity | | |
|---|---|--|
| Marmot (2010) Policy Area: Give every child the best start in life and Strengthening the role and impact of ill health prevention | | |
| Action | Primary Agency/ agencies | Measure |
| Policy area 1a.1: Increase the number of healthy births | | |
| To deliver a 6 week 'Healthy Mums, Healthy Bumps' weight management and dietary intervention for pregnant women to support pregnancy health and develop sustainable healthy habits among families. | TWBC Health Team in partnership with MTW midwifery team | No. of mums referred and engaged with programme. Demonstration of behaviour change among completers. |
| To support pregnant women to achieve and maintain a healthier weight through 3 pregnancy appointments with the healthy weight midwife service. | Maidstone and Tunbridge Wells NHS hospital trust | No. of women supported and behaviour change achieved. No. of referrals to Healthy Mums, Healthy Bumps |
| To provide timely advice, guidance and signposting to families at 5 key time points through health visiting service | KCHT Health Visiting Team | All families seen on time |
| Policy area 1a.2: Increase breast-feeding initiation and prevalence rates at 6-8 weeks | | |
| To promote breast feeding friendly environments by working with businesses, employers, food establishments and other public facilities such as shopping malls helping businesses understand the need to provide support through policies and facilities for women who want to breastfeed. | PSB (supported by TWBC health team) | Demonstration of breast feeding friendly environments by displaying the logo No. of business reached and displaying good practice |
| To increase breastfeeding initiation and uptake in Tunbridge Wells by providing peer support. | PSB, KCC, Activmob, CIC and children's centres | Increase in breastfeeding initiation rates (target 95% coverage at 6-8 weeks) Contact with mothers within 48 hours of transfer home after birth or 48hrs from time of home birth. |
| Policy area 1b.3: Promote healthy weight for children | | |
| To deliver an 8 week family weight management course (LEAP) in schools within our highest priority wards supporting parents with overweight and obese children through cooking, nutrition and exercise. | TWBC health team | 50 families recruited per annum (target) Families who complete to demonstrate behaviour change which supports a sustained reduction in weight. Year R and Year 6 obesity rates from the National Child |

| | | |
|---|---|---|
| | | Measurement Programme for obesity falling |
| To identify schools in need of support using NCMP results. Schools are supported to provide healthier environments through tailored enhancement plans, parental engagement activities, curriculum support and targeted interventions. | TWBC health team, KCHT healthy schools & school nursing, SSP and FLOs | Reduction in Year R and Year 6 obesity as measured by National Child Measurement Programme No. of schools and families reached, interventions delivered |
| Policy area 2.3: Support disabled people to live safe, independent and fulfilled lives | | |
| To deliver a tailored weight management programme (Move, Eat, Grow) for adults with learning disabilities to improve access to dietary support and weight management interventions. | TWBC health team | No. of people supported Demonstration of behaviour change and weight loss for those completing the course |
| Policy area 3.2: Support businesses to have healthy workplaces | | |
| To engage business in public health through promotion and delivery of the Kent Healthy Business Awards. This supports and tasks businesses to make improvements in 9 areas including healthy eating, smoking and and physical activity to facilitate a healthier workforce. Also contributes to priority 5 & 6 | TWBC health team and KCC | No. of businesses engaged per annum (target: 1 new business to achieve national award, 10 new businesses signed the declaration, 10 themes assessed as excellent and 20 new businesses actively engaged). |
| Policy area 5.2: Develop communities to be healthy places | | |
| To deliver the cycling strategy in Tunbridge Wells supporting an increase in the numbers who cycle | TWBC economic development | Increase in the number of people who cycle and use sustainable transport |
| To provide, maintain and enable use of good quality green spaces, play equipment and leisure facilities. | TWBC planning, sports and parks | Surveys establish how well spaces are being used |
| Policy area 6.1: Improve access to screening | | |
| To screen all eligible 40-74 year olds cholesterol levels, blood pressure, weight (BMI) and lifestyle choices (diet, exercise & alcohol); enabling early identification of risk factors for diabetes, stroke, CHD, kidney disease and certain types of dementia. Also contributes to priority 5&6 | KCHT health checks, GP surgeries, pharmacies and TWBC health team | 50% of eligible patients invited to a health check per annum (Kent Joint Health and Wellbeing Strategy Target) Advice, support, signposting and referrals for timely help. |
| Policy area 6.2: Reduce the gap in health inequalities across the social gradient | | |
| To provide free school meals to all key stage 1 pupils and children from low income families so that children have access to a hot, nutritious meal daily. | KCC | No. of who have taken part versus no. eligible |
| To develop physical literacy in primary schools through training and | Tonbridge and West Kent | Improved, higher quality PE delivered in schools, |

| | | |
|--|---------------------------------|---|
| support funded by sports premium funding. | School Sports Partnership (SSP) | demonstrated by No. of schools worked with. |
| To deliver the change for life clubs at primary schools across Tunbridge Wells giving children the opportunity to active and learn about healthy living | SSP | No. of clubs running across Tunbridge Wells No. of children attending clubs |
| To teach families and residents to cook healthy meals from scratch on a budget through mosaic cookery classes. | TCHG | No. of people supported |
| To deliver 1:1 health trainer service for people aiming to improve their lifestyle through modifications to diet, alcohol reduction, weight loss, smoking cessation and support with wellbeing. Also contributes to priority 5 & 6 | KCHT health trainers | No. of clients supported Demonstration of behaviour change |
| To deliver the 10 week subsidised exercise referral programme across Tunbridge Wells for patients who can use exercise to support their weight loss. | TWBC health team, Fusion | No. of clients support (target 105) No. of clients demonstrating weight loss and/ or behaviour change |
| To deliver the 10 week free adult weight management programme (Weight For It), helping people to manage their diet and lifestyle in a community setting for clients whose BMI is below 40. | TWBC health team | No. of people engaged No. of people losing and maintain weight loss No. of people changing behaviours |
| To deliver the tier 3, 'For healthy weight' weight management intervention including, dietary, emotional and exercise support in patients whose BMI is above 40. | For Healthy Weight (TWBC) | No. of people engaged No. of people losing weight No of people making behaviour changes |
| Policy area 6.5: Make every contact count | | |
| To deliver cookery, nutrition, physical health, wellbeing and walking sessions for users of Tunbridge Wells Mental Health Resource Centre (TWMHRC) | TWMHRC | No. of service users supported to live healthy lifestyles |

| Priority 5: Smoking related deaths | | |
|--|--|--|
| Marmot (2010) Policy Area: Give every child the best start in life Create and develop healthy and sustainable places and communities Strengthen the role and impact of ill health prevention | | |
| Action | Primary Agency/ agencies | Measure |
| Policy area 1a.1: Help increase the number of healthy births | | |
| Midwives to measure CO levels in all pregnant women and refer smokers to the 'Baby Clear' service providing vulnerable families with early help to quit | KCHT Stop Smoking Service and MTW midwifery department | Reduction in the number of mums that smoke during pregnancy. No. of referrals made |
| To train all children's centre staff in level 1 brief intervention for smoking cessation to improve access to advice and support when giving up smoking | Stop smoking service and children's centres. | No. of staff trained No. of people supported to quit and No. of referrals made |
| Policy area 3.2: Support businesses to have healthy workplaces | | |
| To provide in house smoking cessation resources to local businesses, where a minimum of 8 quitters have been identified, including 1:1s and quit clubs. | KCHT stop smoking service | No. of sessions run and no. of people quit per annum |
| Policy area 6.2: Reduce the gap in health inequalities across the social gradient | | |
| To deliver dedicated 1:1, group and telephone support to people who wish to quit in community settings | KCHT stop smoking service | No. of people quitting No. of sessions held |
| Policy area 6.5: Make every contact count | | |
| To raise awareness of the effects of 2 nd hand smoke and the benefits of stopping smoking through working with patients attending pulmonary rehab services during the acute (smoking) project. | KCHT stop smoking service | No. of sustained quitters |
| To supplement the Kent schools curriculum with tobacco education to raise awareness of the risks of tobacco use | Kent Schools | No. of schools and children reached |
| To deliver brief advice training for frontline staff so they are equipped to carry out brief interventions and signposting with people who may be supported to quit smoking. | KCHT stop smoking service | No. of sessions delivered and No. of people reached |

| Priority 6: Alcohol Misuse | | |
|--|---|--|
| Marmot (2010) Policy Area: Strengthening the role and impact of ill health prevention | | |
| Action | Primary Agency/agencies | Measure |
| Policy area 5.3: Support safe communities | | |
| To re-launch the Safer Socialising Award and encourage licensees to take part in the scheme | Safe Town Partnership, TWBC CCTV, West Kent Police | No. of awards issued |
| To enforce the Town Centre Alcohol Control Zone | TWBC, West Kent Police | Number of section 27s given by police which have been monitored by CCTV |
| To exclude individuals convicted of violent offence from 'Pubwatch' licensed premises. | Pubwatch (Safe Town Partnership, TWBC CCTV, West Kent Police) | No. of pubwatch exclusions in force |
| To use safe town radios to prevent and detect violent crime, by sharing intelligence between licenses/retailers, CCTV control room and police | Safe Town Partnership, TWBC CCTV, West Kent Police | Pubwatch instigated incidents monitored by CCTV No. off violent offences monitored |
| To review all hate crimes within the borough at CSU meetings and put into place suitable interventions and referrals where appropriate | Safe Town Partnership, TWBC CCTV, West Kent Police | No. of hate crimes recorded in the borough |
| Provide licensing training to staff around responsibilities when serving alcohol; including: making sure they adhere to the licensing act, under-age sales, legal highs and drug use. | West Kent Police | Number of training sessions offered by Kent Police |
| Policy area 6.2: Grow partnerships and find new ways to target and deliver services | | |
| To deliver a holistic approach to drug and alcohol treatment and support including (blood borne viruses) BBV testing, vaccinations, mental wellbeing scores, mental health and substance misuse assessments, groups, clinics and support with sleep hygiene, relaxation and safer use. Involves joint working with health professionals and hospitals. | CRI | No. of people supported and outcome of behaviour change |
| To deploy substance misuse workers to hotspots within the borough to carry out 1:1 and group work with adults and young people | CRI, Kenward Trust | Number of young people worked with through 1:1s and early intervention Number of referrals to KYDIS |

| | | |
|--|--------------------|---|
| | | via Kent Police |
| Policy area 6.5: Make every contact count | | |
| To deliver brief (alcohol) advice training to public facing staff so that they are able to offer brief intervention and signposting, improving access to support for the public. | Kent Public health | No. of sessions held and no. of people trained. |

7. Appendix A

List of Strategic Partners including HAT members

- Tunbridge Wells Public Services Board
- Good Neighbours
- Home Instead
- Tunbridge Wells Community Safety Unit
- Domestic Abuse Voluntary Support Service
- Town and Country Housing Group
- Kent Community Health Trust
- Fusion Lifestyle
- CAB
- Tunbridge Wells Mental Health Resource Centre
- Kent High Weald Partnership
- West Kent Area Mind
- Tonbridge and West Kent School Sports Partnership
- Tunbridge Wells Over Fifties Forum
- Health Watch
- Voluntary Action Within Kent
- KCC libraries
- KCC Children Centres
- Common Work
- Maidstone and Tunbridge Wells NHS hospital trust – Dietetics & Midwifery

8. Appendix B

Glossary

Living in Poverty Definition:

“People are said to be living in poverty if their income and resources are so inadequate as to preclude them from having a standard of living considered acceptable in the society in which they live. Because of their poverty they may experience multiple disadvantage through unemployment, low income, poor housing, inadequate health care and barriers to lifelong learning, culture, sport and recreation. They are often excluded and marginalised from participating in activities (economic, social and cultural) that are the norm for other people and their access to fundamental rights may be restricted”²⁶

Poverty may be measured using information about income, consumption, level of material deprivation and wellbeing. It can be caused by wordlessness, low-paid work and inadequate benefits. The people most likely to be affected by poverty are families with children, lone parents, people with a disability, certain ethnic minorities and workless families or households²⁷.

Fuel Poverty Definition:

‘Fuel poverty in England is measured by the Low Income High Costs definition, which considers a household to be fuel poor if:

- they have required fuel costs that are above average (the national median level)*
- were they to spend that amount, they would be left with a residual income below the official poverty line.*

Prior to the introduction of the Low Income High Costs indicator in England, fuel poverty was measured under the 10% indicator. Under this indicator, a household is considered to be fuel poor if they were required to spend more than 10% of their income on fuel to maintain an adequate standard of warmth.”²⁸

²⁶ European Commission (2004) Joint Report on Social Inclusion
<http://www.jrf.org.uk/sites/files/jrf/poverty-definitions.pdf>

²⁷ Child Poverty in Action Group (2015) <http://www.cpag.org.uk/content/who-lives-poverty>

²⁸ Department of Energy and Climate Change (2014) Annual Fuel Poverty Statistics Report
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319280/Fuel_Poverty_Report_Final.pdf